

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3967

CERTIFICATE OF DEATH

Reg. Dist. No.

03950

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE PLAINS.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE PLAINS			
c. LENGTH OF STAY IN 1b 10 yrs				d. STREET ADDRESS Rt. 301 -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First EVA Middle AKON Last BRADBURN				4. DATE OF DEATH Month APRIL Day 10 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 16 1905	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) WASHINGTON, D. C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HARRY JONES				14. MOTHER'S MAIDEN NAME UNKNOWN (GERARDINA) HARRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT MAHLON E BRADBURN WHITE PLAINS, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 156.1 DUE TO Transition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 days DUE TO Carcinoma of Liver & Metastases (c) 1 yr				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on April 8, 1956 , and that death occurred at 7:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Yahel M. Seron M.D.				ADDRESS (Street, city or town, state) Apexes, Md DATE SIGNED 4/11/56			
PHYSICIAN'S NAME (Type) YAHIEL M. SERON MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-12-1956		22c. NAME OF CEMETERY OR CREMATORY Washington Natl. Pk.		22d. LOCATION (City, town, or county) (State) Switland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Washington, D.C. ADDRESS				24a. REC'D BY REGISTRAR 4/13/56 DATE		24b. REGISTRAR'S SIGNATURE M.L. Thomas	

CERTIFICATE OF DEATH

2003

BUREAU V. B.

APR 13 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3968 CERTIFICATE OF DEATH

03951

Reg. Dist. No. 101

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pisgah</u> TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Eliza</u> (First) <u>Victoria</u> (Middle) <u>Carter</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>21</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9-28-86</u>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>69</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Ripley, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>William Queen</u>		14. MOTHER'S MARDEN NAME <u>Eliza Victoria Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Robert Carter, Pisgah, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>443X</u> IMMEDIATE CAUSE (A) <u>Hypertensive Heart Disease</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) (C)		INTERVAL BETWEEN ONSET AND DEATH <u>69 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)	
21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/12</u> , 19 <u>56</u> , to <u>4/21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>56</u> , and that death occurred at <u>3P</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Frank G. Pusum</u> M.D.		ADDRESS (Street, city, town, state) <u>Indian Head, Md</u> DATE SIGNED <u>4-21-56</u>	
23. BURIAL, CREMATION, REMOVAL-(SPECIFY) <u>Cremation</u>	DATE THEREOF <u>April 25/56</u>	NAME OF CEMETERY OR CREMATORY <u>St Charles</u>	LOCATION (City, town, or county) (State) <u>Chesmont Md</u>
24. REC'D BY REGISTRAR <u>Mary Switzerland</u>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <u>Olsonout Benkin</u>	ADDRESS <u>1702 12th St Washington D.C.</u>
DATE <u>4-22-56</u>			

302B CERTIFICATE OF DEATH

101

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	

MASSACHUSETTS

MAU Y. S.

APR 24 1956

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Handwritten signature and date at the bottom of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3959

CERTIFICATE OF DEATH

03952
 Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac Heights d. STREET ADDRESS 9 Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Farrell Middle Farrell Last Farrell				4. DATE OF DEATH Month April Day 13 Year 1956			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-13-56	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) yrs. 1		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph Adrain Farrell				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Joseph A. Farrell, Potomac Heights, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 776x Prematurity DUE TO ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None				INTERVAL BETWEEN ONSET AND DEATH None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-13-56 to 4-13-56 that I last saw the deceased alive on 12 , and that death occurred at 2:38 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE E. J. Edelen				DATE SIGNED La Plata, Md. 4-13-56			
PHYSICIAN'S NAME (Type) E. J. Edelen, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/14/56		22c. NAME OF CEMETERY OR CREMATORY Ripley, 2nd		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Farrell				24a. REC'D BY REGISTRAR 4/14/56			
ADDRESS Potomac Heights				24b. REGISTRAR'S SIGNATURE Julia H. Baser			

BOURBAU V. 5

APR 17 1956

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03953

3970 CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>Md</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hughesville</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Hughesville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <i>Mary D Foll</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>Apr. 25 1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Widow</i>	8. DATE OF BIRTH <i>Feb 14 1867</i>
9. AGE last birthday <i>89</i> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H W</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Ches Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Henry B. Swann</i>		14. MOTHER'S MAIDEN NAME <i>Rose Oliver</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>Edna Montgomery Hughesville</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Coronary Heart Failure</i>		<i>3-56</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertension</i>		<i>?</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Diabetes</i>		<i>?</i>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3</i> , 19 <i>56</i> , to <i>4-25</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4-24</i> , 19 <i>56</i> , and that death occurred at <i>3</i> M, from the causes and on the date stated above.			
SIGNATURE <i>E. P. Delen</i>		ADDRESS (Street, city, town, state) <i>4-25-56</i>	
DATE <i>5/7/56</i>		M.D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4/28/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Oak Lawn</i>		LOCATION (City, town, or county) (State) <i>Dundalk Md</i>	
24. REC'D BY REGISTRAR <i>Julia H. Hagen</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Laplace</i>	
ADDRESS			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH BUREAU OF VITAL RECORDS CERTIFICATE OF DEATH

BUREAU V. S.

MAY 9 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03954

3971

CERTIFICATE OF DEATH

Item #7, Film G196, 4/30/56, mb

Reg. Dist. No. 106

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Bryans Road</i>				TOWN <i>Bryans Road</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Charles</i> (Middle) (Last) <i>Henson</i>				(Month) (Day) (Year)			
<i>Charles</i>				<i>April 21 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>Male</i>	<i>Colored</i>	<i>WIDOWED</i>	<i>Not known</i>	<i>Over 65 yrs.</i>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Laborer</i>		<i>(Common laborer)</i>		<i>Pomokeny Md.</i>		<i>U.S.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Not known</i>				<i>Not known.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>Not known</i>		<i>Route 1, Box 131A, Indian Head, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A)				INTERVAL BETWEEN ONSET AND DEATH			
<i>4434</i>				<i>5-6 yrs.</i>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1950</i> to <i>4/21</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>4/19</i> , 19 <i>56</i> , and that death occurred at <i>5:34</i> A.M. from the causes and on the date stated above.							
SIGNATURE <i>Frank A. Quisenberry</i>				ADDRESS (Street, city, town, state) <i>Indian Head, Md.</i>			
				DATE SIGNED <i>4-21-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>4-24-56</i>		<i>Macadoinia Baptist Cemetery</i>		<i>Bryans Road, Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>APR 26 1956</i>		<i>Mrs. Odley Luck</i>		<i>The Hunt Funeral Home</i>		<i>Waldorf, Md.</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Name: Charles
Age: 35
Sex: Male
Race: White

Date of Death: April 21, 1956

Place of Death: Home
Cause of Death: (Complicated) Pneumonia
Manner of Death: Natural

Signature: [Signature]
Date: April 21, 1956

Signature: [Signature]
Date: April 21, 1956

Signature: [Signature]
Date: April 21, 1956

Signature: [Signature]
Date: April 21, 1956

Signature: [Signature]
Date: April 21, 1956

Signature: [Signature]
Date: April 21, 1956

RECEIVED
APR 26 1956
BUREAU V. S.

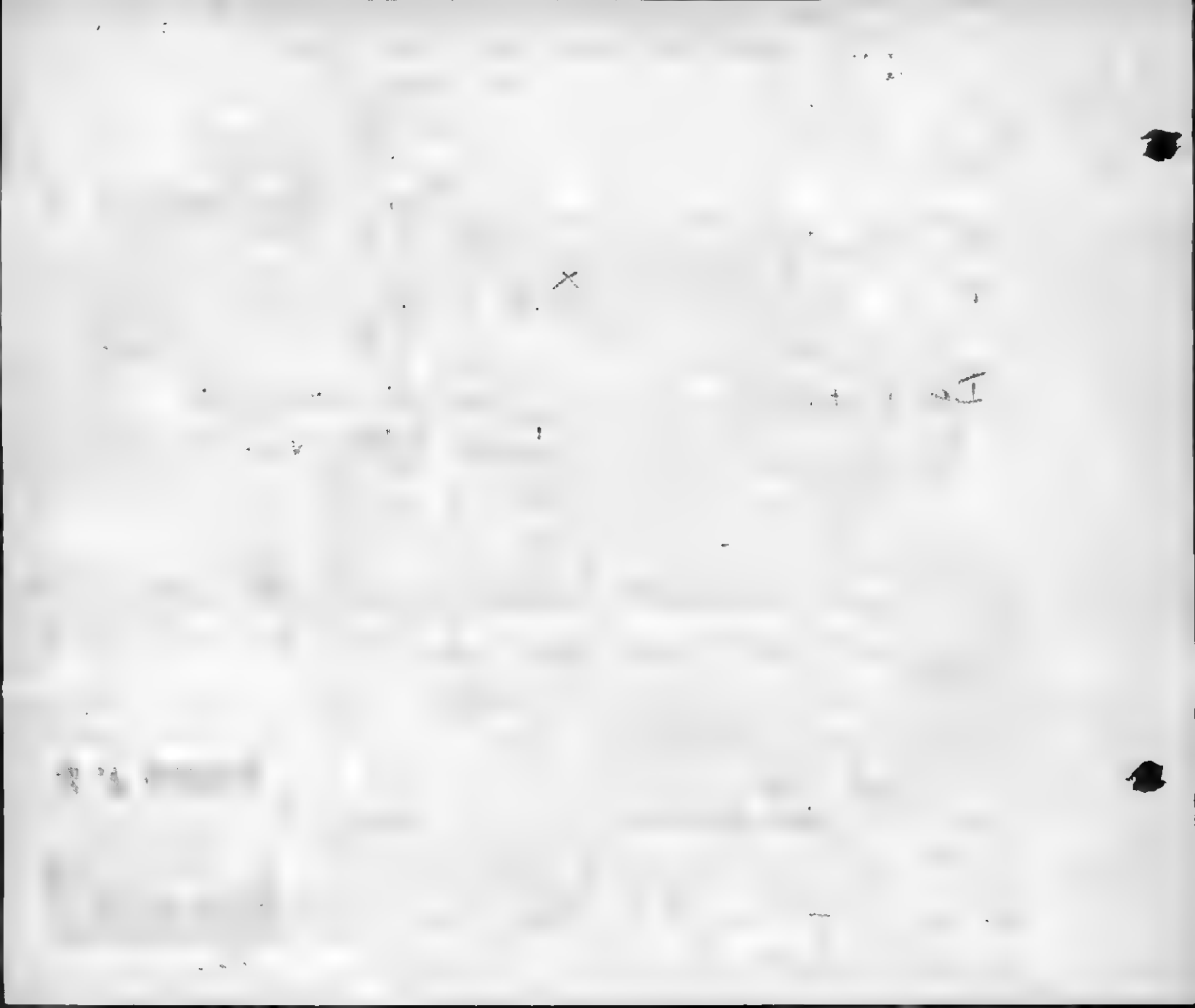
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3972 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03955

Reg. Dist. No. 106

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Brandywine</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>—</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>5205-Cherry Chase Pkwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BART</u> First <u>MICHAEL</u> Middle <u>HERSH</u> Last 4. DATE OF DEATH <u>APR 1</u> 19 <u>56</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>JAN. 31, 1939</u> 9. AGE (In years last birthday) <u>17</u> yrs. 10. UNDER 1 YEAR Months <u>—</u> Days <u>—</u> 11. UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>N.Y. City</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>DAVID HERSH</u> 14. MOTHER'S MAIDEN NAME <u>NETTIE SHERMAN</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>DAVID HERSH-5205 Ch. Ch. Pkwy DC</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ANOXIA</u> <u>925.4</u> DUE TO <u>SLEEPING IN CLOSED CAR</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CHARCOAL BURNER IN CAR - BURNING</u> (c) <u>4-1-56</u> </div> <div style="width: 35%; text-align: right;"> INTERVAL BETWEEN ONSET AND DEATH <u>4-1-56</u> </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>—</u> a. m. <u>—</u> p. m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, off campus, etc.) <u>CAMP</u> 20f. (City or town) <u>BRANDYWINE</u> (County) <u>CHARLES</u> (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. J. Edelen</u> EXAMINER'S NAME (Type) <u>E. J. EDELEN M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>4/4/1956</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u> 22d. LOCATION (City, town, or county) <u>Hyattsville MD</u> (State) <u>MD</u>		23. REGISTRAR'S SIGNATURE <u>Charles J. ...</u> ADDRESS <u>4217-9th St NW</u> 24. REC'D BY REGISTRAR <u>APR 3 1956</u> 24b. REGISTRAR'S SIGNATURE <u>...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03956

Reg. Dist. No. 100

3973

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Benedict</i> c. LENGTH OF STAY IN lb <i>Left</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Benedict</i> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Engene</i> First <i>C.</i> Middle <i>Holth</i> (Holtz) 4. DATE OF DEATH <i>April</i> Month <i>15</i> Day <i>1956</i> Year				5. SEX <i>Male</i> 6. COLOR OR RACE <i>Col.</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Jan 15, 1941</i> 9. AGE (In years last birthday) <i>15</i> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Student</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Holth</i> (Holtz)				14. MOTHER'S MAIDEN NAME <i>Delta Thomas</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Thomas Holth, Benedict</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SHOCK & Trauma Cerebrum</i> DUE TO (b) <i>multiple fractures; comp rt tibia, frac</i> DUE TO (c) <i>left femur and humerus. Riding bike when</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE AND TION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Riding bike when hit by auto</i>			
20c. TIME OF INJURY Month, Day, Year <i>4-15-56</i> o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) <i>Highway</i>		20f. (City or town) <i>Benedict Chas.</i> (County) (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>E. J. Edelen</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. J. EDELEN M.D.</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <i>4-15-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/18/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Leplata</i>		22d. LOCATION (City, town, or county) <i>Benedict</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leplata Inc.</i> ADDRESS				24a. REC'D BY REGISTRAR <i>4/17/56</i>		24b. REGISTRAR'S SIGNATURE <i>James H. Carey</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

APR 19 1964

APR 19 1964

APR 19 1964

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3974 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03957

Reg. Dist. No.

106

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Prince William</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Occogan</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>W</u> Last <u>Hornbaker</u>				4. DATE OF DEATH Month <u>April</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>11-1-318</u>		9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>But yard</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>					
13. FATHER'S NAME <u>Frank W. Hornbaker</u>				14. MOTHER'S MAIDEN NAME 			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 		17. INFORMANT Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning, accidental</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18a) <u>Was delivering speech out in rough weather and fell off from spot</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>4-8</u> p. m. <u>1956</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River</u>			
20f. CITY OR TOWN <u>Occogan</u>		20g. COUNTY <u>Prince William</u>		20h. STATE <u>Virginia</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank A. Susen</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank A. Susen M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, or OTHER (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-21-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pollock</u>			
22d. LOCATION (City, town, or county) <u>Lorton</u>		22e. STATE <u>Virginia</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hall Funeral Home, Occogan, Va.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-21-56</u>			
24b. REGISTRAR'S SIGNATURE <u>M. L. Moore</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

APR 22 1900

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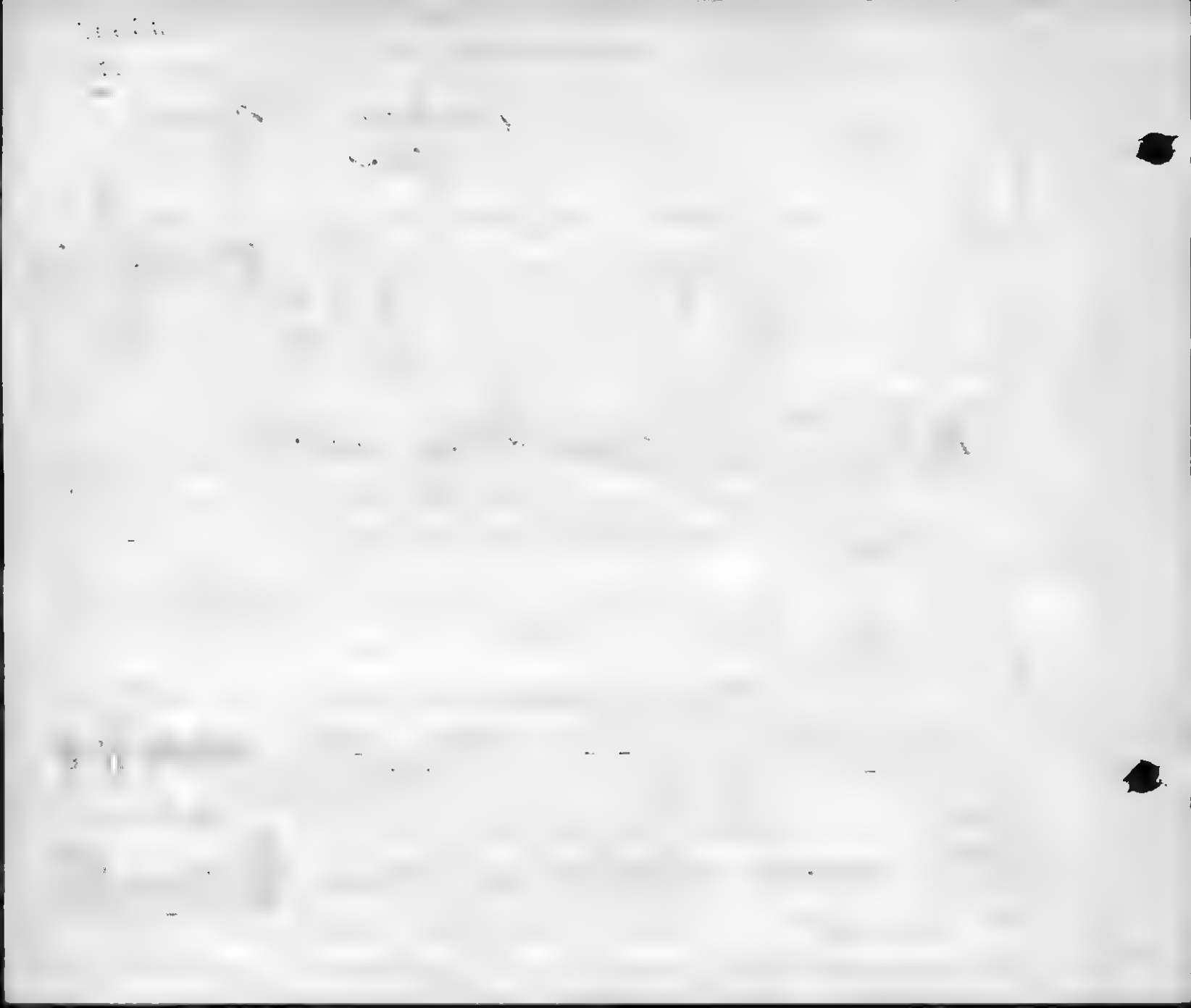
3975

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY <u>Charles County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>			
c. LENGTH OF STAY IN 1b <u>4 hrs</u>				d. STREET ADDRESS <u>La Plata Hospital</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>La Plata Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Jackson</u>			4. DATE OF DEATH Month <u>4</u> Day <u>12</u> Year <u>1956</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>Colored</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-35</u>	9. AGE (In years last birthday) <u>20</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Months	Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Hilltop Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Richard Proctor</u>			14. MOTHER'S MAIDEN NAME <u>Alice Proctor</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-325020</u>		17. INFORMANT <u>Leroy Jackson</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Loss of blood from prolonged labor</u> DUE TO (c) <u>16-hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient was seen for midwife and placenta removed under general anesthesia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. <u>5</u> p. m. <u>19</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County) (State)		
21. I certify that I attended the deceased from <u>4-12-56</u> , 19 <u>56</u> , to <u>4-12-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-12-56</u> , 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James E. Andrews MD</u>			ADDRESS (Street, city or town, state) <u>Indian Head Md</u> DATE SIGNED <u>4/14/56</u>				
PHYSICIAN'S NAME (Type) <u>James E. Andrews MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hill Top, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Perkins</u>			ADDRESS <u>1702 12th St NW</u>		24a. REC'D BY REGISTRAR <u>DATE 4/14/56</u>		
					24b. REGISTRAR'S SIGNATURE <u>Mary E. Sutcliffe</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3976

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> <u>FREDERICK</u> <u>MADDOX</u>		4. DATE <u>4</u> <u>28</u> <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-5-01</u>
9. AGE (In years last b. birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.Y. and FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POWDER FACT</u>	
11. BIRTHPLACE (State or foreign country) <u>V. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>V. S. A.</u>	
13. FATHER'S NAME <u>JAMES FREDERICK MADDOX</u>		14. MOTHER'S MAIDEN NAME <u>IMOGENE LYON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>WIFE</u>	
17. INFORMANT <u>WIFE</u>		Address <u>LA PLATA MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STRANGULATION</u> DUE TO <u>HANGING</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4-28-56</u> DUE TO (c) <u>4-28-56</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>ROPE ABOUT NECK FROM BARN TIE POLE</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30</u> <u>4-28-56</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>BARN</u>	20f. (City or town) <u>LA PLATA</u> (County) <u>CHARLES</u> (State) <u>MD.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. EDELEN</u>		DATE SIGNED <u>4-28-56</u>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Josephs</u>	22d. LOCATION (City, town, or county) <u>Pomfret</u> (State) <u>MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Mc LaPlata</u>		24a. REC'D BY REGISTRAR <u>4/30/56</u> 24b. REGISTRAR'S SIGNATURE <u>John H. Parry</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 3 1

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03960

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE No. CAROL b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PISCATAWAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STELLA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ROGER TRAVIS NOBLES		4. DATE OF DEATH Month 4 Day 8 Year 1956	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-16-33
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Jones Co. M.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME L.P. Nobles		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 239-460966	
17. INFORMANT L.P. Nobles		Address Stella M.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) HEMORRHAGE, INTERNAL DUE TO CRUSHED CHEST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) AUTO ACCIDENT PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. DRIVER OF AUTO WHICH RAN OFF ROAD 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) DRIVER OF AUTO WHICH RAN OFF ROAD 20c. TIME OF INJURY Month, Day, Year 4-8-56 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 20f. (City or town) (County) (State) PISCATAWAY CHAS MD 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 4-8-56		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) PISCATAWAY CHAS MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE E. J. Edelen		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) E. J. EDELEN MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/56	
22c. NAME OF CEMETERY OR CREMATORY Jones Cemetery		22d. LOCATION (City, town, or county) (State) Jones Co M.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Grehart Funeral Home Inc Saplata		24. REC'D BY REGISTRAR 4/10/56	
25. REGISTRAR'S SIGNATURE John H. [unclear]		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

W A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3978

CERTIFICATE OF DEATH

03961

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Phys. Mem. Hospital</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>JOSEPH ALLEN PIRKERTON</i>		4. DATE OF DEATH <i>4 28 1956</i>	
5 SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 30, 1914</i>
9. AGE (In years last birthday) <i>42</i> yrs		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Businessman</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Charles Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph A. Pirkerton</i>		14. MOTHER'S MAIDEN NAME <i>Jane E. Cox</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-14-1582</i>	
17. INFORMANT <i>Mary E. Pirkerton</i>		Address <i>Rock Point Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO (b) <i>Myocardial Infarction</i> DUE TO (c) <i>Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1955</i> <i>1950</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1950</i> , 19, to <i>4-28</i> , 19, that I last saw the deceased alive on <i>4-28</i> , 19, and that death occurred at <i>M</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>E. J. Edelen</i> M.D.			
PHYSICIAN'S NAME (Type) <i>E. J. EDELEN</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5/1/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>		22d. LOCATION (City, town, or county) (State) <i>Wayside Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Mc La Plata</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>4/30/56</i>		24b. REGISTRAR'S SIGNATURE <i>Julia T. Pacey</i>	

BUREAU V. S.

MAY 3 1955

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03962

3979

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CHARLES</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>CHARLOTTE HALL</u>		LENGTH OF STAY (In this place) —		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHARLOTTE HALL</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS —				STREET ADDRESS (If rural give location) —			
3. NAME OF DECEASED (First) (Middle) (Last) <u>RACHEL A. ROLLINS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>4 APRIL 12 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>NOV 25 12 1916</u>	
9. AGE last birthday <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>SARAH P. ANDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>PAUL B. ROLLINS CHARLOTTE HALL, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS, RIGHT</u>						<u>23 MONTHS</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO-SCLEROSIS, GENERALIZED</u>						<u>10 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>L.S. - HTN + HYPERTENSION</u>						<u>2 YEARS</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. —							
19a. DATE OF OPERATION —		19b. MAJOR FINDINGS OF OPERATION —					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) —		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) —		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? —			
22. I hereby certify that I attended the deceased from <u>APRIL 10, 1956</u> , to <u>APRIL 12, 1956</u> , that I last saw the deceased alive on <u>APRIL 10, 1956</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John N. Griffin</u> M.D.				ADDRESS (Street, city, town, state) <u>Hughesville, Md.</u>		DATE SIGNED <u>4/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>DENTSVILLE METHODIST</u>		LOCATION (City, town, or county) (State) <u>DENTSVILLE, MD.</u>	
24. REC'D BY REGISTRAR —		REGISTRAR'S SIGNATURE <u>Mr. Wm. J. Lewis</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home - WARDEN, MD.</u>		ADDRESS —	
DATE —							

3980

CERTIFICATE OF DEATH

03963

Reg. Dist. No.

105

1. PLACE OF DEATH o COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Francis De Sales Semblly</u>		4. DATE OF DEATH Month Day Year <u>April 16, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1885</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
10a. BIRTHPLACE (State or foreign country) <u>Charles Co. Md</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. FATHER'S NAME <u>Richard</u>		12. MOTHER'S MAIDEN NAME <u>Rebecca Greenfield</u>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		14. SOCIAL SECURITY NO.	
15. INFORMANT <u>Marie Semblly Waldorf, Md</u>		Address	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocardial Failure</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
17. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
19. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>12</u>		20. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22. (City or town) (County) (State)	
23. I certify that I attended the deceased from <u>Mar 30, 1956</u> to <u>April 16, 1956</u> , that I last saw the deceased alive on <u>April 15, 1956</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Vahel M. Seroumo</u> M.D.		DATE SIGNED <u>4/16/56</u>	
PHYSICIAN'S NAME (Type) <u>VAHEL M. SEROUMO</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE THEREOF <u>April 19, 1956</u>	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		ADDRESS <u>1000 N. ...</u>	
26a. REC'D BY REGISTRAR <u>APR 20 1956</u>		26b. REGISTRAR'S SIGNATURE <u>Min M. L. Monroe</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 21 1900

RECEIVED
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File-pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3981

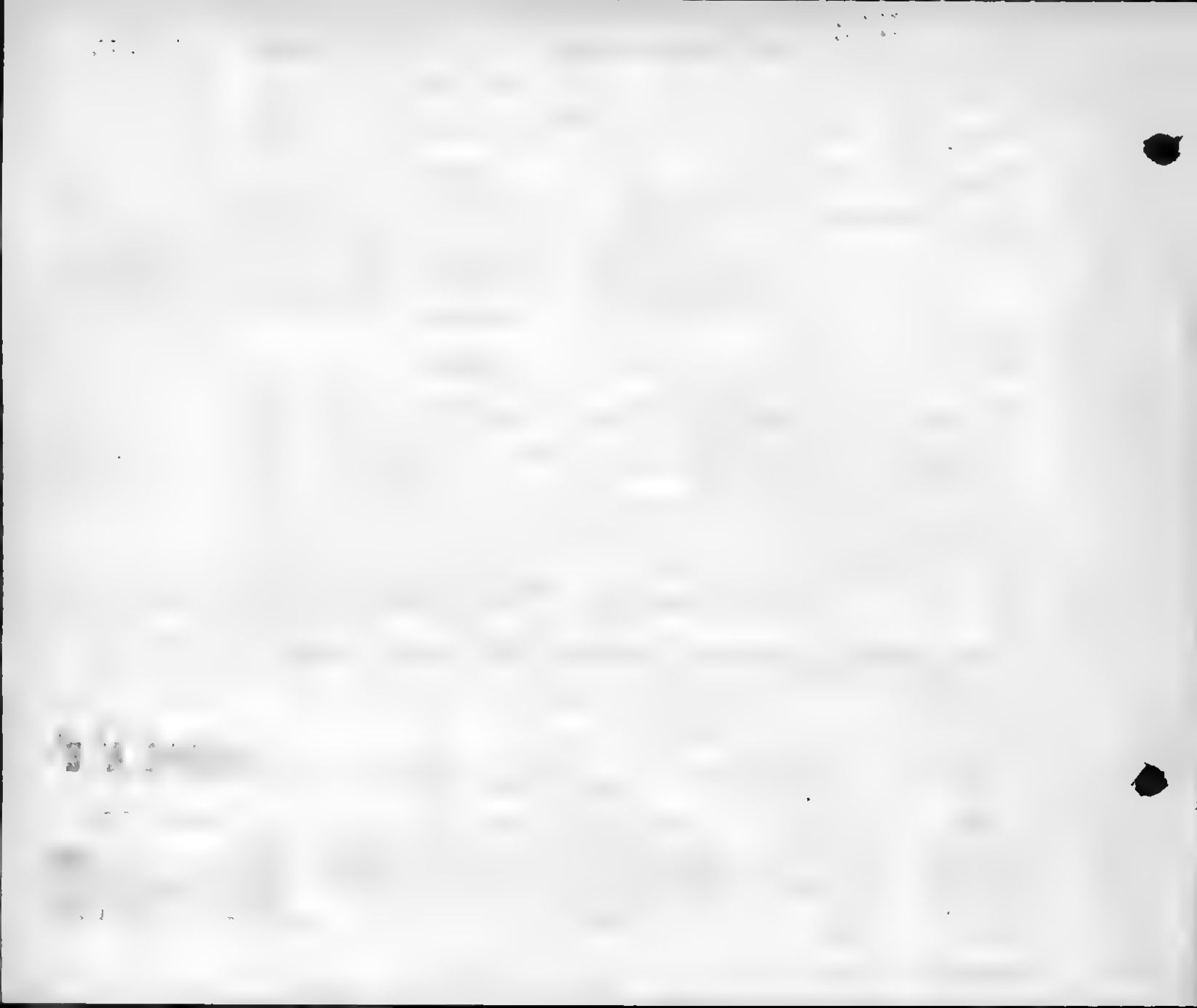
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03964

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u>		c. LENGTH OF STAY IN 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Physicians Memorial</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELMER</u> First Middle Last <u>THOMAS</u>				4. DATE OF DEATH Month <u>4</u> Day <u>11</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 24</u>		9. AGE (In years last birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Chas Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Elmer Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Rosealia Crang</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mrs. Carrie Thomas Hughesville</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO <u>Gen. Art. Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4-11-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
EXAMINER'S SIGNATURE <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>4-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Bryantown MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home Warden, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

4-11-56



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03966
3982 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rison</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rison</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Arleston Oliver Wheeler</u>		4. DATE OF DEATH <u>April 14 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1936</u>
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Charles Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oleaver Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Alice C Sperry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215-36-5721</u>	
17. INFORMANT <u>Oleaver Wheeler</u>		Address <u>Danvers Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Multiple fractures of face & skull</u> (c) <u>auto accident</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4-14-56</u> <u>4-14-56</u> <u>4-14-56</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto which went out of control</u>	
20c. TIME OF INJURY Month, Day, Year <u>4-14-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Rison Charles Md</u>	
21. I certify that I took charge of the remains described above; held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. J. Edelen</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/16/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chickenshire</u>		22d. LOCATION (City, town, or county) (State) <u>Chickenshire Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archard Inc., La Plata Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>4/17/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julius W. Carey</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3.

APR 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3983 CERTIFICATE OF DEATH

03967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Lola Middle May Last Willet		4. DATE OF DEATH Month April Day 20 Year 1956		5. SEX F.		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-2-05		9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Unk.				12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME William Henry Robey								14. MOTHER'S MAIDEN NAME Arsilla Davis									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 214 18 8447				17. INFORMANT Irene Willett				Address Brandywine, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Apoplexy 442X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) C.V.R. Disease DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 1938 1956 , to Apr-18 , 1956 , that I last saw the deceased alive on 4/18 , 1956 , and that death occurred at 1 A M , from the causes and on the date stated above. ACTUAL SIGNATURE THE HUNT M.D. Waldorf, Md. DATE SIGNED 4/21/56 PHYSICIAN'S NAME (Type)																	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-23-56				22c. NAME OF CEMETERY OR CREMATORY Piney Church Cem.				22d. LOCATION (City, town, or county) Waldorf, Maryland (State)					
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home Waldorf, Md.								24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE M. L. M...					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

2055

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		35		Jan 15 1920		New York City	
Cause of Death		Manner of Death		Occupation		Education		Religion	
Heart Disease		Natural		Teacher		High School		Catholic	
Physician's Signature		Signature of Informant		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death	
April 10 1956		10:30 AM		Home		Heart Disease		Natural	
Burial Place		Burial Date		Burial Time		Burial Place		Burial Date	
Catholic Cemetery		April 12 1956		10:00 AM		Catholic Cemetery		April 12 1956	

RECEIVED
APR 24 1956
BUREAU V. 2